

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0045920

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11433

STATE FILE NUMBER

## 1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN *St. Louis*

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION *City Hospital*

Inside Limits  
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN

Inside Limits  
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)  
*1438 Chambers*

Reside on Farm  
Yes ☐ No ☐

## 3. NAME OF DECEASED

(Type or print)

First

Middle

Last

*EDDIE PLANK*

4. DATE OF DEATH

Month

Day

Year

*11-13-67*

## 5. SEX

*Male*

## 6. COLOR OR RACE

*White*

7. Married ☐ Never Married ☐  
Widowed ☐ Divorced ☐

## 8. DATE OF BIRTH

*Unk*

## 9. AGE (last birthday)

*53*

IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Retired*

10b. KIND OF BUSINESS OR INDUSTRY

*Retired*

11. BIRTHPLACE (City and state or country)

*Unk. g.*

12. CITIZEN OF WHAT COUNTRY

*Unk.*

13a. FATHER'S NAME

*Unk.*

13b. MOTHER'S MAIDEN NAME

*Unk.*

14. NAME OF HUSBAND OR WIFE

*Unk.*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. *494-07-1676*

17. INFORMANT Address *Helene L. Taylor, 1300 Clark*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

*Pulmonary embolism right lung  
bilateral acute pulmonary edema  
(non traumatic) Embolism of the liver*

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

*5810*

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from *6:00 Pm* to *6:00 Pm* and last saw her alive on *11/13/67*  
Death occurred at *6:00 Pm* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

*Albert H. Happe, Inc., 4700 Washington Blvd.*

*DEC 6 1967*

*Paul Smith, M.D.*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Not Embalmed

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.